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For the Well-Being of Minnesota's Foster Children: What Federal Legislation Requires

Gail Chang Bohr

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FOR THE WELL-BEING OF MINNESOTA'S FOSTER CHILDREN: WHAT FEDERAL LEGISLATION REQUIRES

Gail Chang Bohr[†]

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I. INTRODUCTION

The health and well-being of children in foster care received the spotlight in April 2004, with the release of the results of the Child and Family Service Reviews (CFSR) conducted by the United States Department of Health and Human Services (USDHHS).¹

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1. Robert Pear, *U.S. Finds Fault in All 50 States' Child Welfare Programs, and Penalties May Follow*, N.Y. TIMES, Apr. 26, 2004, at A16 [hereinafter N.Y. TIMES].

None of the states—Minnesota included—passed the seven outcomes related to safety, permanency, and well-being under the CFSR.² Indeed, Minnesota is among sixteen states that did not meet any of the seven standards.³ The findings came as a surprise to the assistant secretary of health and human services supervising the reviews who stated, “Kids in the child welfare system deserve better than a minimal standard of care.”⁴ Deficiencies included “significant numbers of children suffering abuse or neglect more than once in a six-month period; caseworkers not visiting children often enough to assess their needs; and not providing promised medical and mental health services.”⁵

The health and well-being of Minnesota’s foster children should be the concern of all Minnesotans because the foster children of today are the adults of tomorrow with the potential to be productive, taxpaying citizens. But whether they will succeed in reaching their potential goals depends on how well they are treated in the foster care system and how well the system prepares them for that future.

The federal government has taken a stand and has mandated that the child’s health and safety are paramount considerations in decision-making by the responsible social service agency.⁶ A number of federal laws provide the impetus. The Adoption and Safe Families Act (ASFA) of 1997 required tracking of outcome measures for children in foster care and increased accountability of child welfare agencies.⁷ Outcome measures and tracking are carried out under the federal Child and Family Service Review regulation, part of the 1994 Congressional mandate to review the states’ performances in the delivery of services to children and families in child protection and foster care.⁸

In 1997, ASFA clarified that the goal of the CFSR review process is to assess the states’ actual outcomes for children and families and to determine whether states are complying with the

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. Mary Lee Allen & Mary Bissell, *Safety and Stability for Foster Children: 14 The Policy Context*, THE FUTURE OF CHILDREN: CHILDREN, FAMILIES, AND FOSTER CARE, 53-54 (2004) [hereinafter Allen & Bissell].

7. Adoption and Safe Families Act, Pub. L. No. 105-89 (1997).

8. 42 U.S.C. § 677 (2002).

federal legal requirements.⁹ The CFSR is, therefore, a comprehensive and hands-on assessment process¹⁰ that monitors and evaluates child and family services, including protective services, family preservation and support, foster care, independent living and adoption services.¹¹ Another way to measure health and well-being outcomes is by tracking whether eligible children are participating in the Early Periodic Screening Diagnostic and Treatment (EPSDT) program, part of Medicaid that has been available since 1967 to provide a comprehensive set of preventive and health services to Medicaid eligible persons under age twenty-one.¹² Children in foster care are eligible for the EPSDT program, also known as Child and Teen Checkups (C&TC) in Minnesota.¹³ The participation rates in the C&TC program in Minnesota is an indication of how well children in foster care are accessing medical and mental health services.¹⁴ Also, the Foster Care Independence Act, known as the John H. Chafee Foster Care Independence Program, was passed in 1999 to help children who are likely to remain in foster care until age eighteen to have a successful transition outcome from foster care.¹⁵

Even though there is legislation in place that describes the services that Minnesota children need to have successful outcomes, how the legislation is enforced and how the services are delivered will affect the outcome for the child.¹⁶ Tracking outcomes through the Child and Family Service Reviews is one way that the USDHHS

9. Adoption and Safe Families Act, Pub. L. No. 105-89.

10. Allen & Bissell, *supra* note 6, at 54, 55.

11. MINNESOTA DEPARTMENT OF HEALTH & HUMAN SERVICES, *Child and Family Services Review: Executive Summary* (Nov. 6, 2004), available at <http://www.acf.hhs.gov/programs/cb/cwrp/executive/mnes.pdf> [hereinafter *Executive Summary*].

12. MINNESOTA DEPARTMENT OF HUMAN SERVICES 1999 EXTERNAL QUALITY REVIEW STUDY CHILD AND TEEN CHECKUPS PARTICIPATION RATE REVIEW FINAL REPORT 1 (Aug. 2000) [hereinafter EXTERNAL QUALITY REVIEW]. The EXTERNAL QUALITY REVIEW was commissioned by the Minnesota Department of Human Services after DHS calculated that only twenty-seven percent of eligible children had participated in the C&TC (as EPSDT is named in Minnesota) in 1998. *Id.* at 5. The purpose of the study was to learn more about the care actually being provided to children eligible for the C&TC program. *Id.* Minnesota DHS contracted with FMAS Corporation, a DynCorp Company, to perform the external review of participation in the program. *Id.*

13. *Id.*

14. *Id.*

15. 42 U.S.C. § 677 (2002).

16. See generally MINN. STAT. ch. 260.

reviews the work of the states and ensures that child welfare agencies are carrying out the mandates. Another is for lawyers and other advocates working for children to ensure that children receive the services they are entitled to – services that advance their health and well-being.¹⁷

In 2005, Children's Law Center of Minnesota (CLC) marks ten years of making a difference for children by making their voices heard in the systems that affect them.¹⁸ CLC has recruited and trained hundreds of volunteer lawyers, who have given thousands of pro bono hours representing children in the foster care system. CLC crafted legal arguments and strategies to make the best case on behalf of the child in the child welfare, judicial, health and education systems.¹⁹

Lawyers working for children contribute to their health and well-being by giving them some measure of dignity and control over decisions that affect them and that have a positive effect on their well-being. For the children CLC represents, having a lawyer is the difference between having a voice in judicial proceedings and feeling helpless and hopeless about the future. CLC staff and volunteer lawyers advocate for youth in foster care who want to complete high school while remaining in foster care even though they have reached their eighteenth birthday. They advocate for siblings to remain together or at least maintain contact when the plan is to separate them and place them in different homes. CLC staff and volunteer lawyers help undocumented youth who are abused, neglected, or abandoned to apply for special immigrant juvenile status so they can remain and work legally in the United States.²⁰ CLC also advocates for appropriate mental health services

17. Open child protection proceedings also afford observation of court proceedings to determine whether meaningful services that meet the child's needs are provided. See generally Heidi S. Schellhas, *Open Child Protection Proceedings in Minnesota*, 26 WM. MITCHELL L. REV. 631 (2000).

18. This milestone anniversary coincides with the 100th anniversary of Juvenile Court in Minnesota.

19. See Gail Chang Bohr, *Giving Voice to the Voiceless: Lawyers for Children*, THE HENNEPIN LAW. 18 (Sept. 2000) [hereinafter Bohr].

20. For unaccompanied and undocumented children who are abused, neglected, or abandoned, for whom a finding of long term foster care is made, and for whom it is not in their best interests to return to their country of origin, it is in their best interests to remain under the jurisdiction of the juvenile court until the Special Immigrant Juvenile Status application is granted. Without the Special Immigrant Juvenile Status, unaccompanied children are doomed to a life in the shadows, unable to return to their country of origin, and unable to work legally in

for children before they are discharged from the foster care system without services in place.²¹

Ironically, while there is urgency to finding permanent homes for children in foster care, those very children are falling behind in the measures for health and well-being. This is particularly so for older teens in foster care who do not find permanent homes and who are unable to return to their families of origin.

For older teens, health and well-being means having a clinic that they can go to and establish medical assistance. It means having educational success and making plans for the future. It means being in school (one that is appropriate to the child's educational needs) and graduating.²² It means having a place to stay so they can at least complete high school as they make the transition from foster care to living on their own.

the United States. See generally ABA STEERING COMMITTEE ON THE UNMET LEGAL NEEDS OF CHILDREN: AMERICA'S CHILDREN STILL AT RISK 365-389 (2001) [hereinafter ABA STEERING COMM.]. Some states like Florida tried to deny foster care benefits to undocumented alien children; a federal suit for injunctive relief under 42 U.S.C. § 1983 was brought on behalf of an illegal immigrant child on discrimination grounds. Carolyn S. Salisbury, *The Legality of Denying State Foster Care to Illegal Alien Children: Are Abused and Abandoned Children the First Casualties in America's War on Immigration?*, 50 U. MIAMI L. REV 633, 634-35 n. 9 (1996). Another plaintiff was added and a motion to certify the class of abused and abandoned immigrant children was filed. *Id.* at 635 (citing Stipulation of Settlement, *Doe v. Towey*, No. 94-1696-CIV-FERGUSON (S.D. Fla. filed Feb. 14, 1995)). The State settled the case before the motion was heard. The Federal Special Immigrant Juvenile Status requires cooperation between the state and federal governments. Under the federal statutory scheme, the state court must declare the child dependent on the state and eligible for long-term foster care. The state's refusal to do so frustrates the federal immigration statute and usurps Congress' plenary authority over immigration matters.

21. CLC, a member of the Children's Mental Health Partnership, developed the Children's Mental Health project and was awarded an Equal Justice Works Fellow to implement it.

22. CLC of Minnesota is a founding member of the National Children's Law Network (NCLN) made up of eight children's law centers across the United States that came together to forge a national policy agenda and to develop outcome measures. The members of the National Children's Law Network are: Children and Family Justice Center - Northwestern University School of Law; Children's Law Center of Massachusetts, Children's Law Center of Minnesota, JustChildren, Virginia, Oklahoma Lawyers for Children, Public Counsel, California, Rocky Mountain Children's Law Center, Colorado, Support Center for Child Advocates, Pennsylvania. NCLN's national policy initiative is education. All the players in the child welfare and delinquency systems—judges, county attorneys, children's lawyers, social workers, guardians ad litem—ensure that each child is in school, the right school, and finishes school. NCLN's education initiative is underscored in an op-ed piece from the *Washington Post*. Andrew Block & Virginia Weisz, *Choosing Prisoners Over Pupils*, WASH. POST, July 6, 2004, at A19.

Minnesota's less than passing grade in the CFSR extends to all the outcome measures and in particular, for purposes of this article, in the educational, physical and mental health arena where Minnesota also needs to improve.²³ While the states have been given an opportunity to submit program improvement plans, there are penalties involved for not meeting the outcome measures.²⁴

Lest anyone believe that meeting educational needs lies solely in the province of the schools, the CFSR makes clear that meeting the educational needs of the child comes under the aegis of the child welfare system.²⁵ The CFSR noted that in Minnesota there was too much reliance on foster parents to see to the children's educational needs.²⁶ Furthermore, the CFSR makes it clear that the multiple school changes were related to multiple placement changes.²⁷ Also, Minnesota did not have enough information available about the child's education needs because school records are seldom included in the child protection case records.²⁸ Similarly, Minnesota needs to improve in the outcome measure of meeting the physical and mental health needs of children because again there is an over reliance on foster parents to address the child's physical and mental health needs.²⁹ Moreover, mental health issues were typically not addressed for the foster child.³⁰

This article will discuss the federal legislation and regulations—ASFA and CFSR—that hold the states accountable for the health and well-being of children and adolescents in foster

23. *Executive Summary*, *supra* note 11, at 5-6. The other outcome measures are: Safety Outcome 1, Children are, first and foremost, protected from abuse and neglect; Safety Outcome 2, Children are safely maintained in their homes whenever possible and appropriate; Permanency Outcome 1, Children will have permanency and stability in their living situation; Permanency Outcome 2, The continuity of family relationships and connections will be preserved for children; Well-Being Outcome 1, Families will have enhanced capacity to provide for their children's needs; Well-Being Outcome 2, Children receive appropriate services to meet their educational needs; and Well-being Outcome 3, Children receive adequate services to meet their physical and mental health needs. *Id.* at 2-6.

24. 45 C.F.R. § 1355.36 (2004); *see also* N.Y. TIMES, *supra* note 1.

25. *Executive Summary*, *supra* note 11, at 1.

26. *Id.* at 5.

27. *Id.*

28. N.Y. TIMES, *supra* note 1.

29. *Executive Summary*, *supra* note 11, at 6.

30. N.Y. TIMES, *supra* note 1. CLC of Minnesota's experience in this regard is that too often children are not receiving mental health therapy even after having psychological assessments that recommend therapy.

care.³¹ This article will also discuss how the Early Periodic Screening Diagnosis and Treatment (EPSDT) program, the comprehensive health care services that states are required to provide through Medicaid,³² is used to address the health and well-being of children and adolescents in foster care.³³ Critical to a discussion on the well-being of foster youth is the Chafee Foster Care Independence Act of 1999³⁴ that emphasized the states' responsibility to ensure that youth in foster care have the services and means to make a successful transition from foster care.³⁵ Finally, this article will describe how CLC's social workers and lawyers, working as a team, provide holistic representation that advances the health and well-being of the child in foster care.

II. THE NEED FOR FOSTER CARE

As long as children are abused, neglected, or abandoned by their parents or other custodial caretakers, there is a need for foster care—a form of substitute care that is meant to be a stand-in for parents. Nationwide, there are over half a million children in foster care at any given time.³⁶ Every year, over 250,000 children are removed from their homes due to abuse or neglect and are placed in foster care.³⁷ The USDHHS reported that as of June 2001 some 581,000 children were in foster care.³⁸ Forty percent of the children entering foster care were eleven years of age or older—29% are between the ages of eleven and fifteen and 11% are between the ages of sixteen and eighteen.³⁹ Forty-four percent of

31. See *infra* Parts III-IV.

32. Karen Aileen, *Health for Teens in Care: A Judge's Guide*, A.B.A. CENTER ON CHILD. AND L. 6, 2002 [hereinafter *Health for Teens in Care*]. "Medical Assistance" is the Minnesota term for "Medicaid." MINN. STAT. § 256B.01 (2002).

33. See *infra* Part V.

34. 42 U.S.C. § 677 (2004).

35. For example, the CFSR noted that under the permanency outcome measure the independent living plan was not completed for all foster youth sixteen and older. U.S. Dep't of Health and Human Servs. Admin. for Children and Families, *Minnesota State Final Report* Part A(II)(8) (Aug. 2001), available at <http://www.acf.hhs.gov/programs/cb/cwrp/staterpt/mn.htm>.

36. Richard E. Behrman, *Executive Summary*, 14 THE FUTURE OF CHILDREN: CHILDREN, FAMILIES, AND FOSTER CARE 1, 1 (2004) [hereinafter THE FUTURE OF CHILDREN].

37. *Id.*; see also U.S. Dep't of Health and Human Servs. Admin. for Children and Families, Children's Bureau, *The AFCARS Report*, Interim FY 1999 estimates as of June 2001, cited in *Health for Teens in Care*, *supra* note 32, at 1.

38. *Health for Teens in Care*, *supra* note 32, at 1.

39. Ruth Massinga & Peter J. Pecora, *Providing Better Opportunities for Older*

the children who were already in foster care were eleven years or older.⁴⁰

In Minnesota, more than 9400 children were abused and neglected in 2002;⁴¹ 11,300 children were in family foster care and 78% were reunited with their birth parents or found permanency with relatives.⁴²

Because of abuse and neglect, the majority of children who enter foster care have already been exposed to conditions that compromise their chances for a healthy development.⁴³ Poverty and maltreatment are conditions associated with developmental delays and, in the case of maltreatment, behavioral problems, emotional disorders, and even compromised brain development.⁴⁴ Children in foster care have more physical and mental health problems than do children in the general population.⁴⁵ A nationwide study conducted in 2000 reported that about twenty percent of children in out-of-home care have developmental disabilities, mental retardation, cerebral palsy, speech impairments, hearing impairments, sight impairments, and learning disabilities.⁴⁶

Added to the physical and mental health needs are the developmental needs of the children in care. The USDHHS noted that positive youth development means that adolescents receive the services and opportunities necessary to develop “a sense of competence, usefulness, belonging, and empowerment.”⁴⁷

Even though children in foster care have access to health insurance through their state’s Medical Assistance, they do not receive the care they are entitled to. Indeed, there is even an underutilization of EPSDT,⁴⁸ the federal comprehensive preventive

Children in the Child Welfare System, 14 THE FUTURE OF CHILDREN 151, 152 (2004) [hereinafter Massinga & Pecora].

40. *Health for Teens in Care*, *supra* note 32, at 1.

41. Minn. Dep’t of Human Servs., *Child Protection*, available at http://www.dhs.state.mn.us/main/groups/children/documents/pub/DHS_is_000152.hcsp (last visited Jan. 6, 2005).

42. Minn. Dep’t of Human Servs., *Foster Care and Other Out-of-home Placement*, available at http://www.dhs.state.mn.us/main/groups/children/documents/pub/DHS_id_000164.hcsp (last visited Jan. 6, 2005).

43. Sandra Bass et al., *Children, Families, and Foster Care: Analysis and Recommendations*, 14 THE FUTURE OF CHILDREN 5, 10 (2004) [hereinafter Bass].

44. *Id.*

45. *Id.*

46. *Health for Teens in Care*, *supra* note 32, at 6 (citing Child Welfare League of America, *Fact Sheet: The Health of Children in Out-of-Home Care* (2000)).

47. Massinga & Pecora, *supra* note 39, at 152.

48. In Minnesota, the EPSDT program is known as the Child and Teen

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and health services program for children. Because they move so often from foster home to foster home, there is no continuity of care with the same medical provider, which often results in inconsistent medical care and gaps in the treatment provided.⁴⁹ In 1995, the United States General Accounting Office (GAO) reported that 12% of children in care had not received routine health care, 34% had not received any immunizations, only 10% received services for developmental delay, and even though 75% of the children were at high risk of exposure to HIV, fewer than 10% had been tested.⁵⁰

The American Academy of Pediatrics (AAP) in 2000 and 2002 issued guidelines on meeting the developmental and health care needs of children in foster care. The AAP recommended the following:

- Children should receive a health evaluation shortly after, if not before, entering foster care to identify any immediate medical needs;
- Children should receive a thorough pediatric assessment within 30 days of entry;
- Children should be assigned a consistent source of medical care (“a permanent medical home”) to ensure continuity of care;
- Children should receive ongoing developmental, educational, and emotional assessments.⁵¹

Not only was the AAP concerned about the lack of continuity of medical care for children in care, it was also alarmed that the multiple moves that occur for children in care can have deleterious effects on “the young child’s brain growth, mental development, and psychological adjustment” because of the attendant disruption and uncertainty for the child that occur with such moves.⁵²

Checkups (“C&TC”) program. In this article, the terms are used interchangeably. EXTERNAL QUALITY REVIEW, *supra* note 12, at 1-2.

49. Bass, *supra* note 43, at 10. See generally ABA STEERING COMM., *supra* note 20, at 67-115.

50. Bass, *supra* note 43, at 10 (citing U.S. Gen. Accounting Office, *Foster Care: Health Needs of Many Children are Unknown and Unmet* 2 (May 26, 1995), available at <http://www.gao.gov/archive/1995/he95114.pdf>).

51. Bass, *supra* note 43, at 10.

52. Bill Grimm & Isabelle Hurtubise, *Child and Family Service Reviews, Part II: An Examination of Placement and Visitation*, J. OF THE NAT'L CENTER FOR YOUTH L. 14, 16 (Jan-Mar. 2003) (citing the American Acad. of Pediatrics, *Policy Statement on Developmental Issues for Young Children in Foster Care* (RE0012) (Nov. 2000)) [hereinafter Grimm & Hurtubise].

The statistics about the lack of medical care are even more stark when set against the Child Welfare League's statement that between 30-40% of children in the child welfare system have physical health problems including delayed growth and development, HIV infection, neurological disabilities, malnutrition, and asthma.⁵³ Furthermore, vision, hearing, and dental problems are also prevalent among children in foster care.⁵⁴

III. ADOPTION AND SAFE FAMILIES ACT (ASFA)⁵⁵

The risks to the well-being of children and youth who have been abused, neglected, and abandoned come not only from the initial abuse but also during the time they spend in care. For the first time in federal law, ASFA explicitly made the child's health and safety a paramount concern.⁵⁶ It also mandated that no later than January 1, 1999, "the State shall develop and implement standards to ensure that children in foster care placements in public or private agencies are provided quality services that protect the safety and health of the children."⁵⁷

ASFA, together with the Child and Family Services Review (CFSR), are hailed as two of the most influential and far-reaching policies of the federal oversight of the states' child welfare systems.⁵⁸ Commentators emphasize that this is the first time that federal law categorically made the child's health and safety paramount in decision making at all the stages of the child protection process, from removal of the child, return of the child, the care in the foster home or in another permanent family to making the transition to live independently.⁵⁹

Under ASFA, states are required to develop standards to protect the health and safety of children in foster care and to check

53. *Health for Teens in Care*, *supra* note 32, at 4 (citing Child Welfare League of America, *Fact Sheet: The Health of Children in Out-of-Home Care*).

54. *Id.*

55. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, 111 Stat. 2115 (codified at 42 U.S.C. § 1305 (2000)).

56. *Id.*; see also Allen & Bissell, *supra* note 6, at 53.

57. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 308, 111 Stat. 2133 (codified at 42 U.S.C. § 671(a)(22) (2004)).

58. THE FUTURE OF CHILDREN, *supra* note 36, at 8; Allen & Bissell, *supra* note 6, at 53; *Health for Teens in Care*, *supra* note 32, at 5.

59. Allen & Bissell, *supra* note 6, at 53. ASFA also expedited timelines for permanency decision making and made clear that nothing in federal law required that a child must remain in or be returned to an unsafe home. *Id.*

the criminal records of both foster and adoptive parents as a condition for foster care and adoption funding.⁶⁰ States are also required to give foster parents and other caregivers an opportunity to speak at any court hearing.⁶¹ This specific directive is meant to give care providers the opportunity to challenge the quality of services provided by agencies to children in care.

Furthermore, a new directive included in ASFA is that of well-being.⁶² "For adolescents in foster care, well-being means health, education, and independent living planning for those who remain in foster care to help them transition successfully out of foster care when they are no longer eligible for services."⁶³ This new emphasis on health and well-being has the potential to truly benefit adolescents, who in spite of the Foster Care Independence Act of 1999, have continued to exit the foster care system with just the clothes on their backs, without medical care, without a place to live, without a high school education, and without a job, or at least one that pays a livable wage.⁶⁴

To measure outcomes, ASFA requires that the child's health and education needs and services be reported in case records that are maintained by the court and by the child protection agencies responsible for the custody, care, and control of the child.⁶⁵ At long last, adolescents in care may be able to have judges pay attention to their education, health, and well-being before they are discharged from the system.

60. *Id.* at 50-51.

61. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 104, 111 Stat. 2120 (codified at 42 U.S.C. § 675(5)(G) (2000)).

62. Adoption and Safe Families Act of 1997, Pub. L. No. 105-89, § 305, 111 Stat. 2132; *see also Health for Teens in Care*, *supra* note 32, at 5.

63. *Health For Teens in Care*, *supra* note 32, at 5.

64. There are occasional bright spots that interrupt this bleak landscape. In at least one county in Minnesota, the judge orders a youth in transition conference when the child turns sixteen which starts the process for the county to begin to develop a plan for the child to learn the skills to live on his or her own. With the child's attendance at hearings, the judge monitors the progress of the child and the appropriateness of the plan and expects the child to complete high school before she will discharge the child from foster care. In many instances, this judge has maintained jurisdiction under Minnesota Statute section 260C.193, subdivision. 6 (2004). With the expectation that the youth in this county will complete school and go on to college, many young people express a desire to remain in the foster care system even past their eighteenth birthday in order to complete high school and go on to higher education.

65. Allen & Bissell, *supra* note 6, at 54-57.

IV. CHILD AND FAMILY SERVICE REVIEW (CFSR)⁶⁶

The CSFR finally brings focus to the child's health and well-being. Although the CSFR is an important initiative for reviewing each state's performance and had been authorized in the 1994 Amendments to the Social Security Act to ensure conformity with the requirements in titles IV-B and IV-E of the Social Security Act, they had not been implemented until ASFA gave critical incentive to the Department of Health and Human Services to carry out these much needed reviews.⁶⁷ Up to this point, reviews had focused primarily on assessing the state agencies' compliance with *procedural* requirements, as evidenced by case file documentation, rather than on the *substance of results* of services and the states' capacities to produce positive outcomes for children and families.⁶⁸ The final rule, published in 2000 by the USDHHS, established a new approach to monitoring state child welfare programs. States are now assessed for substantial conformity with federal requirements for child protection, foster care, adoption, family preservation and family support, and independent living services.⁶⁹

The CFSRs are an important tool for the Children's Bureau to (1) ensure conformity with the federal child welfare requirements; (2) determine what is actually happening to children and families as they are engaged in child welfare services; and (3) assist states to enhance their capacity to help children and families achieve positive outcomes.⁷⁰ Ultimately, the goal of the CFSRs is to improve services and outcomes for children and families in the area of safety, permanency, and family and child well-being.⁷¹

Minnesota needs to improve results in seven outcomes. For safety, the outcomes to be achieved are: (1) children are, first and foremost, protected from abuse and neglect; and (2) children are safely maintained in their homes whenever possible and appropriate. For permanency, the outcomes to be achieved are: (1) children will have permanency and stability in their living situation; and (2) children will continue to have family

66. 45 C.F.R. § 1355.10 (2004).

67. Allen & Bissell, *supra* note 6, at 55; Children's Bureau Child and Family Services Reviews, *Fact Sheet* (Prepared by the Child Welfare Review Project), Aug. 2002 [hereinafter CFSR Fact Sheet].

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

relationships and connections. For family and child well-being, the outcomes to be achieved are: (1) families will have enhanced capacity to provide for their children's needs; (2) children will receive appropriate services to meet their educational needs; and (3) children will receive adequate services to meet their physical and mental health needs.⁷²

For example, one indication of well-being in the CFSR, is that siblings maintain relationships with one another when they are not placed together.⁷³ Indeed, it has long been noted that "preserving the bond between siblings is essential to their long-term well-being."⁷⁴ Conversely, research shows that separating siblings contributes to a high rate of placement failures.⁷⁵ The Child Welfare League of America (CWLA) recommends that "when children are taken from their homes *and* families, all attempts should be made to keep siblings together."⁷⁶

The CWLA further stated that siblings should be placed apart only if their development needs and safety require it.⁷⁷ If siblings cannot be placed together initially, the caseworker should focus on visitation and eventual reunion of the siblings.⁷⁸ The CWLA also noted, "Attachments among siblings are an often neglected but potentially powerful source of constancy for a child, particularly when attachments with parents are tenuous."⁷⁹ Being placed

72. *Id.*; *Executive Summary*, *supra* note 11, at 2-6; *see supra* note 23 and accompanying text.

73. Grimm & Hurtubise, *supra* note 52, at 25.

74. *Id.* (quoting "Siblings in Out of Home Care: An Overview," Casey Family Programs, 2002, 4-7, *available at* http://www.casey.org/cnc/documents/sibling_overview.pdf). "[T]he National Leadership Symposium on Siblings in Out-of-Home Care, co-sponsored by the Casey Family Programs National Center for Resource Family Support and the Florida-based Neighbor to Family Program, developed several recommendations on siblings in foster care." *Id.*

75. *See, e.g.*, Grimm & Hurtubise, *supra* note 52, at 24 (citing D. BERRIDGE & H. CLEAVER, *FOSTER HOME BREAKDOWN* (Oxford: Basil Blackwell, 1997)).

76. *Id.*

77. *Id.*

78. *Id.*

79. Child Welfare League of America, *Standards of Excellence for Family Foster Care Services*, Standard 2.43 (1995). Minnesota issued a Program Improvement Plan (PIP) on sibling visits. It remains to be seen how individual counties will implement the PIP and truly improve in the area of sibling visits. There are also inconsistencies in the CFSR Reports. For example, Minnesota's Final Report noted that counties made efforts to ensure that siblings maintained contact; however parent and sibling visitation was considered an area that needed improvement. Grimm & Hurtubise, *supra* note 52, at 28. Grimm and Hurtubise also noted that "[i]n quite a few states, the statewide data was contradicted by the

together reduces the trauma of foster care and reinforces the importance of family relationships.

Implementing the CFSRs will have a positive effect on the health and well-being of children by reviewing the actual outcomes achieved for children.

V. THE EARLY PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROGRAM

Another way to measure the health and well-being of children in foster care is by reviewing the participation rate of children in foster care in the Early Periodic Screening Diagnosis and Treatment (EPSDT) program.⁸⁰ Known in Minnesota as the Child and Teen Checkup, EPSDT provides a comprehensive set of preventive and health care services to Medicaid eligible persons under age twenty-one.⁸¹ EPSDT has been around since 1967 when Congress expanded the children's health component of Medicaid to include EPSDT.⁸² In 1987, states were prohibited from excluding any services that Federal Medicaid law recognized, even if that service was denied to adults in that state.⁸³ The EPSDT program aims to provide:

Early assessment of a child's health so that possible disease and disabilities can be prevented or detected;

Periodic assessment of a child's health at critical points in physical and mental development;

Screening tests and procedures to determine whether further examination of the child needs to occur because of a physical (including dental) or mental condition;

Diagnostic tests and procedures to determine the nature and cause of condition identified through screenings;

Treatment services that control, correct, or reduce physical and mental health problems.⁸⁴

The Health Care Financing Administration (HCFA) set a goal of an 80% participation rate.⁸⁵ "Nationally, only 56% of eligible

findings in the on-site reviews." *Id.* at 15.

80. EXTERNAL QUALITY REVIEW *supra* note 12, at 1-2.

81. *Id.* at 1.

82. *Id.*

83. *Id.*

84. *Id.* at 1-2.

85. *See id.* at 2.

children received EPSDT services in 1996.”⁸⁶

EPSDT has set intervals when screening should occur.⁸⁷ For example, in early childhood, the child is seen every one to three months until twenty-four months of age.⁸⁸ After twenty-four months, the next screening occurs at age three.⁸⁹ Then, from the age of three until six, the schedule is yearly and then changes to every other year until the child turns twenty.⁹⁰

In Minnesota, the Minnesota Department of Human Services (DHS) ensures that all Medicaid enrolled children have access to health screening and treatment.⁹¹ Access is provided through fee-for-service or in one of two managed care programs, the Prepaid Medical Assistance Program (PMAP) or MinnesotaCare.⁹² About 230,000 children are enrolled in the two managed care programs.⁹³ In 1998, Minnesota DHS calculated that Minnesota's participation rate for the C&TC is 27%, which is well below the 80% goal set by HCFA and below the 56% national average.⁹⁴

It was at that point that Minnesota DHS contracted with FMAS Corporation, an external company, to perform an external review of participation in the program.⁹⁵ The primary objective was to assess C&TC participation rate through chart abstraction.⁹⁶ Documentation of clinic visits were based on administrative data supplied by each health plan and verified by the child's medical record.⁹⁷ Participation rates were based on medical record documentation of the required components in the C&TC program.⁹⁸ The sample was drawn from all children eligible to receive a C&TC screen any time in 1998, regardless of length of enrollment in the public health programs.⁹⁹ Mental health statistics were not kept.¹⁰⁰

86. *Id.*

87. *Id.*

88. *Id.* at app. B.

89. *Id.*

90. *Id.*

91. *Id.* at 2.

92. *Id.*

93. *Id.*

94. *Id.*

95. *Id.* at *Executive Summary*.

96. *Id.* at 2-3.

97. *Id.* at 5.

98. *Id.* at 1-2.

99. *Id.* at 5.

100. In some states, parents have been required to give up custody of their

The study's key findings are that about 50% of children in Minnesota's health programs are not accessing primary/preventive healthcare services.¹⁰¹ From the health plan administrative data and the medical record review, only 52% of children eligible to receive services had documented clinic visits in 1998.¹⁰² Sixty-nine percent of children due for a C&TC screen had a clinic visit in 1998.¹⁰³ Moreover, only 6% of children in Minnesota's public health programs received comprehensive developmental screens while 15% of children eligible and due for a C&TC screen also had referral for corrective treatment documented in the medical record.¹⁰⁴

The study concluded that although DHS and the health plans are trying to increase C&TC participation rates over the past few years, participation rates have remained low.¹⁰⁵ DHS has also undertaken several initiatives to increase the participation rates such as communications with parents, providers, professional organizations and state agencies.¹⁰⁶

The majority of children in foster care are covered under EPSDT because they are eligible for Medical Assistance.¹⁰⁷ If children in foster care are receiving physical and mental health check-ups on a regular basis, or at least as often as required under EPSDT, the participation rates for the C&TC should at least be commensurate with the number of children in foster care.¹⁰⁸ The fact that the participation rates are so low at 27% and are well below the national figure indicates what the CFSR already reported; that children in foster care in Minnesota are not receiving annual or periodic physical check-ups as mandated by law, and their physical and mental health needs are not being met.¹⁰⁹

Adolescents in foster care are also entitled to medical care, but

child in order to access mental health services because medical coverage does not cover the full array of mental health treatment. Susan H. Badeau, *Five Commentaries: Looking to the the Future*, 14 THE FUTURE OF CHILDREN: CHILDREN, FAMILIES, AND FOSTER CARE 175, 176 (2004).

101. EXTERNAL QUALITY REVIEW, *supra* note 12, at *Executive Summary*.

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.*

109. *Id.*

are not receiving it. When they exit the foster care system, many are leaving without their medical assistance cards and do not have any idea about where they should go for medical care when they are sick. Moreover, EPSDT extends to age twenty-one, but only 48% of children in the nineteen to twenty age range received an initial or periodic screen for which they were eligible.¹¹⁰ Ironically, without specific directions about which doctor or clinic to go to, many youth wait until they are so sick that they end up in the emergency room, which is a greater cost.

VI. FOSTER CARE INDEPENDENCE ACT OF 1999¹¹¹

Another measure of well-being is how well youth in foster care are prepared to transition from foster care to living independently on their own. All children in the United States, regardless of race, economic status, or educational background, need help in learning to live independently. While child protection statutes define "child" as under the age of eighteen, there is no similar definition of "adult."¹¹² Even where the Minnesota Legislature established that court jurisdiction "shall continue until the individual becomes 19 years of age if the court determines it is in the best interest of the individual to do so," the statute did not use the word "adult."¹¹³

Why is this important? Because nationally, about 20,000 foster youth leave care every year because they have "aged out," meaning that they have reached the age of eighteen so they are no longer eligible for foster care.¹¹⁴ In Minnesota, about 500 children "age out" each year¹¹⁵ because they reached eighteen even though Minnesota law permits children to remain in care under the court's jurisdiction until the child's nineteenth birthday if the child is still in school and the court determines it is in the child's best

110. MINN. DEPT. OF HUMAN SERVS., ANNUAL C&TC PARTICIPATION REPORT-FEDERAL FISCAL YEAR FOR THE PERIOD OF 10/01/2002 THROUGH 9/30/2003, CMS-416.

111. 42 U.S.C. § 677 (2002).

112. *See, e.g.*, MINN. STAT. § 260C.007, subd. 4 (2004) ("Child" means an individual under eighteen years of age).

113. MINN. STAT. § 260C.193, subd. 6 (2004).

114. U.S. Dep't of Health and Human Servs. Admin. for Children and Families, Children's Bureau, *The AFCARS Report #9, available at* <http://www.acf.hhs.gov/programs/cb/publications/afcars/report9.htm> (last visited Feb. 11, 2005).

115. TRANSITIONS: MOVING TOWARD INDEPENDENT LIVING BROCHURE, CHILDREN'S LAW CENTER OF MINNESOTA (citing Wilder Foundation Research).

interest.¹¹⁶

American society seems to have two definitions of adulthood: one for the middle class pertaining to primarily white educated children, and the other for children in the foster care system pertaining to primarily children of color. For children in the middle class, their adulthood does not begin until somewhere in their twenties, while for children in foster care, their adulthood begins at eighteen. A 2003 University of Chicago survey found that most Americans think that adulthood begins at age twenty-six, as many college graduates in their twenties are living with parents because they are not making it on their own.¹¹⁷ While economics may be one reason for this dependence, another is that the maturity level of this generation of children is not what it was a generation ago.¹¹⁸ But, for children in foster care, the expectation is that once they turn eighteen, they are adults, who must now magically find a place to live, finish school, find a job, find medical care, and live happily on their own.¹¹⁹

Nationally, the transition for adolescents from foster care to adulthood is difficult and uncertain. Minnesota is no exception. In 2000, approximately 16% of the 550,000 children in foster care were between the ages of sixteen and eighteen.¹²⁰ African American children make up more than 40% of the foster care population, even though they represent less than 20% of the nation's child population.¹²¹ As The Annie E. Casey Foundation

116. MINN. STAT. § 260C.193, subd. 6 (2004).

117. Martha Irvine, *When Does a Person Become an Adult?*, STAR TRIBUNE, Dec. 4, 2003, at E1. Many of these children no longer have ties to their families of origin.

118. *Id.* at E4. "It's not like one day you wake up and you're an adult. It's much more gradual," according to developmental psychologist, Professor Jeffrey Arnett at the University of Maryland. *Id.*

119.

What is truly surprising is our apparent national expectation that upon reaching 18, these high-risk adolescents will be capable of functioning independently. Common sense dictates that in today's world, most 18-year-olds, regardless of their economic or educational status, are not fully capable of assuming adult responsibilities. In a nationwide survey respondents felt that the average young adult is not ready to be completely on their own until about age 23. A [sic] third didn't consider them ready until age 25 or older.

The Annie E. Casey Foundation, *2004 Kids Count Essay: Moving Youth From Risk to Opportunity* 7 (citing LAKE, SNELL, PARRY AND ASSOCIATES, PUBLIC OPINION ABOUT YOUTH TRANSITIONING FROM FOSTER CARE TO ADULTHOOD (2003) (prepared for the Jim Casey Youth Opportunities Initiative)).

120. *Id.* at 5.

121. *Id.* White children make up 64% of the country's children, but only 31%

noted,

As children move along in age within the foster care system, African-American youngsters are more likely to be in residential or group care instead of family foster care. African-American children also stay in care longer, and they are least likely to be reunified with their families.

The problems of adolescents in foster care are compounded by their considerable and overlapping health and mental health problems. An estimated 30 percent to 40 percent of foster children have physical or emotional difficulties. Those leaving care are at especially high medical risk and likely to have acute, chronic, and complex health needs resulting from past neglect or abuse. Yet a major problem for this population is their lack of even minimal medical coverage.¹²²

In 2001, a longitudinal study of youth leaving care revealed that 44% had problems obtaining health care "most or all of the time."¹²³ Foster youth are behind educationally, have disproportionately high rates of special educational needs and have a 55% or higher dropout rate.¹²⁴

While there is an emphasis on arriving at permanency,¹²⁵ there are implications for the developmental needs and outcomes for older youth who come into care. As noted above, children enter the foster care system at different points in their development. For example, about 38% are five years old or younger when they are placed in care.¹²⁶ On the other hand, 20% of children who enter or reenter care are between the ages of eleven and fifteen.¹²⁷ Another

of the foster care population. *Id.*

122. *Id.*

123. *Id.* at 7.

124. *Id.* There are no good statistics on Minnesota foster youth who have graduated from high school. In 2003, it appears that only 17.5% of the youth aged seventeen to twenty had graduated from high school. See E-mail from Dorothy Renstrom, MSW, Community Partnerships, DHS, to the author (Aug. 31, 2004, 10:24am CST) (on file with author).

125. Permanency has been defined as 'the systematic and continuous process of carrying out a set of goal-directed activities designed to help children live in safe families that offer them a sense of belonging and legal, lifetime family ties.' Massinga & Pecora, *supra* note 39, at 156 (quoting A.N. MALUCCIO, ET AL., PERMANENCY PLANNING FOR CHILDREN: CONCEPTS AND METHODS (Routledge, Chapman, and Hall, 1986)).

126. *Id.* at 152.

127. *Id.*

11% are between the ages of sixteen and eighteen.¹²⁸

The United States Department of Health and Human Services emphasized that “positive youth development means that adolescents [must] receive the services and opportunities necessary to develop ‘a sense of competence, usefulness, belonging, and empowerment.’”¹²⁹

To help children who are likely to remain in foster care until age eighteen years of age, the Foster Care Independence Act, also known as the John H. Chafee Foster Care Independence Program, was passed in 1999.¹³⁰ The Act expanded the Independent Living Initiative of 1986 doubling the funding for independent living services to \$140 million.¹³¹

The purpose of the Chafee Foster Care Independence Program (CFCIP) is to:

- identify children who are likely to remain in foster care until 18 years of age and to help these children make the transition to self-sufficiency by providing services such as assistance in obtaining a high school diploma, career exploration, vocational training, job placement and retention, training in daily living skills, training in budgeting and financial management skills, substance abuse prevention, and preventive health activities (including smoking avoidance, nutrition education, and pregnancy prevention);
- help children who are likely to remain in foster care until 18 years of age receive the education, training, and services necessary to obtain employment;
- help children who are likely to remain in foster care until 18 years of age prepare for and enter post-secondary training and education institutions;
- provide personal and emotional support to children aging out of foster care, through mentors and the promotion of interactions with dedicated adults;
- provide financial, housing, counseling, employment, education, and other appropriate support and services

128. *Id.*

129. *Id.* (quoting U.S. Department of Health and Human Services, Administration for Children and Families, *Positive Youth Development*, Feb. 2003, available at <http://www.ncfy.com/ydfactsh.htm>).

130. *Id.* at 155.

131. *Id.*

to former foster care recipients between 18 and 21 years of age to complement their own efforts to achieve self-sufficiency and to assure that program participants recognize and accept their personal responsibility for preparing for and then making the transition from adolescence to adulthood; and

- make available vouchers for education and training, including post-secondary training and education, to youths who have aged out of foster care.¹³²

Despite the doubled federal spending and expanded eligibility to age twenty-one (less than \$1000 per year, per eligible youth) state and county systems charged with addressing the needs of this population have hardly been up to the challenge.¹³³

Among the states, there is wide variation in the scope and quality of services provided to current and former foster youth.¹³⁴ "In general, states provide minimal and uneven assistance with education, employment, and housing, and only a few states provide essential health and mental health services."¹³⁵ Foster care systems have been slow to respond to the challenge and youth have continued to "age out" without a safety net of housing, medical care, and education.

Perhaps most important, the inability of foster care systems to routinely place teenagers with strong foster, relative, and adoptive families puts them at great risk of not having a network of adults available as they transition to adulthood- a transition that is challenging even for youth who have families supporting them.¹³⁶

Even in Minnesota, youth aging out of foster care continue to lose their safety net at age eighteen without benefit of a transition plan for independent living. In at least one urban county, SELF funds are expended only after the child has left foster care, so the funds are not used to help with transition.¹³⁷ The SELF funds

132. 42 U.S.C.A. § 677(a) (2002).

133. The Annie E. Casey Foundation, 2004 *Kids Count Essay: Moving Youth from Risk to Opportunity* 7, 7-8 (citing SHIRK, M. & G. STANGLER, ON THEIR OWN: WHAT HAPPENS TO KIDS WHEN THEY AGE OUT OF THE FOSTER CARE SYSTEM? (2004)).

134. *Id.* at 8.

135. *Id.*

136. *Id.*

137. SELF is the acronym for Support for Emancipation and Living Functionally, the Minnesota program that disburses the Chafee funds. MINN. DEPT. OF HUMAN SERVS., FAMILY & CHILDREN'S SERVS. DIV., CHAFEE FOSTER CARE

cannot be used to pay rent, and if the child has already been dropped by the system, that child is essentially homeless, which hardly contributes to the child's state of well-being.

The Independent Living Plan, required under the Federal Chafee Foster Care Independent Program and Minnesota statute,¹³⁸ presents an opportunity to help the young person plan for his or her transition from the foster care system. However, the plan is often not completed in collaboration with the young person, the very subject of the plan.¹³⁹

The Chafee Foster Care Independent Program is specific in the requirements to help adolescents make a successful transition from foster care to living on their own.¹⁴⁰ Having an independent living plan in writing is only one aspect of the transition planning. It is also important that the child receives quality services to help implement the plan. For example, educating the child on how to determine where to go for medical care and having the medical insurance card in their possession; knowing how many credits are

INDEPENDENCE PROGRAM ACTIVITIES REPORT, FFY 2003 (June 30, 2004). The Education and Training Vouchers (ETV) have been well received in Minnesota as any child who spent one day in foster care after their sixteenth birthday is eligible. However, there are a limited number of vouchers for the number of eligible youth. Up to \$5,000 in vouchers can be used for post-secondary education costs. Telephone interview with Claire Hill, Minnesota Department of Human Services (Nov. 16, 2004).

138. Minnesota Statutes section 260C.212, subdivision 1(c)(8) states the out-of-home placement plan shall set forth:

an independent living plan for a child age 16 or older who is in placement as a result of a permanency disposition. The plan should include, but not be limited to, the following objectives: (i) educational, vocational, or employment planning; (ii) health care planning and medical coverage; (iii) transportation including, where appropriate, assisting the child in obtaining a driver's license; (iv) money management; (v) planning for housing; (vi) social and recreational skills; and (vii) establishing and maintaining connections with the child's family and community.

Minn. Stat. § 260C.212, subd. 1(c)(8). *See also* MINN. STAT. § 260C.201, subd. 11(g)(4) (stating that the court must review the plan for the child's independence upon the child's leaving long-term foster care living).

139. In fact, Children's Law Center of Minnesota learned that one county is filling out these forms on the computer without consultation with or even knowledge of the young person, who is unaware that a form has been filled out that purports to be that person's independent living "plan." Those forms are submitted as part of a report to the federal DHHS, a clear elevation of form over substance, and no doubt a violation of the letter, if not the spirit, of the Chafee Foster Care Independent Act.

140. *See* Massinga & Pecora, *supra* note 39, at 155.

still needed in order to graduate from high school; getting help in collecting all the credits from all the schools the child attended, even those attended while in a shelter.

Some recommendations are offered that could help to keep track of how well children are doing in foster care. For example, The American Academy of Pediatrics recommends that every child in foster care have a permanent medical home, e.g., a clinic or doctor's office to which the child would return for care even if the child moves foster homes.¹⁴¹ This continuity of medical care helps the child to develop a relationship with a professional—doctor, nurse, medical social worker—who can monitor the child's health and well-being and who can intervene appropriately when decisions are being made that are detrimental to the child's health and well-being.

Another recommendation involves using "passports" for health and education to keep track of clinics and medical treatment and schools the child has attended.¹⁴² Each child in foster care would have a Health Passport where all the information about the child's health and medical provider is in one place. The passport would go with the child no matter where the child is placed. Medical staff would fill out the passport each time the child sees a doctor.

Likewise, with an Education Passport, all the information about the child's schooling and education can be kept so that when credits are missing, it is easy to see where the gaps are. The passport would go with the child no matter where the child is placed. An Education Passport would also help with applications to higher education as all the education information would be in one place.

Foster care youth have aspirations for education similar to youth that are not in foster care.¹⁴³ What is missing is the planning and support needed to close the gap between aspiration and attainment. Having concrete help with these and other independent living areas will go a long way in promoting the health and well-being of the adolescent in foster care and ultimately help

141. Bass, *supra* note 43, at 10.

142. See, e.g., Allen & Bissell, *supra* note 6, at 60.

143. See CONNECTED BY 25: A PLAN FOR INVESTING IN SUCCESSFUL FUTURES FOR FOSTER YOUTH 8-10 (The Youth Transition Funders Group Foster Care Work Group with the Finance Project ed., 2004), available at <http://www.youthtransitions.org/pdf/connectedby25fostercareworkgroupmar2004.pdf>.

them to reach their goals.¹⁴⁴

VII. CHILDREN'S LAW CENTER OF MINNESOTA AND THE ROLE OF THE
ATTORNEY IN SAFEGUARDING THE HEALTH AND WELL-BEING OF
CHILDREN IN FOSTER CARE¹⁴⁵

CLC works to safeguard the health and well-being of children in foster care. In a juvenile protection system that can become too informal and players too familiar with one another, many corners are inadvertently cut.

The majority of children in foster care do not have a lawyer to explain their options or to advocate on their behalf. That means they often get lost in the system. Children's Law Center of Minnesota (CLC) helps to make children's voices heard. When the system does not work, children run away, become homeless, and drop out of school. CLC's programs help children to access the services they need, protect their legal rights, navigate the system, tell the courts what they want, help find a secure, permanent family, finish school, and prepare to live on their own. Having a lawyer can help tell the courts what they want to see happen in their lives, advocate for a secure, permanent family, advocate for services so they can finish school and prepare to live on their own.

Besides providing legal representation, CLC staff and volunteers work closely with the courts, government agencies, and social service organizations to change policies and systems that fail children. To do this, CLC provides training for other child advocates, recommends policies to the courts and government agencies that serve children, and represents the child's point of view in cases affecting children by writing "friend of the court" briefs for the Minnesota Supreme Court, the Eighth Circuit Court of Appeals, and the United States Supreme Court. Thus, CLC's advocacy for policy and system change is grounded in its direct experience representing children.

With the help of CLC's staff attorneys, social workers, and

144. To educate Minnesota social workers about the law requiring an independent living plan for foster youth making the transition from foster care to living on their own, CLC of Minnesota, in collaboration with Hennepin County Children, Family and Adult Services and others, developed and organized a conference that was held on May 28, 2003 at William Mitchell College of Law. CLC also produced a comprehensive manual, *Transitions for Success: Preparing Foster Youth for Living Independently* (2003) (on file with author).

145. See Bohr, *supra* note 19.

volunteer lawyers, CLC provides a multidisciplinary approach to representing children in the foster care system. This holistic approach is assisted by CLC's staff social worker who is trained in working with children and who helps lawyers to develop an understanding of the psycho-social development of the child they represent and how the foster care system is working for that child.

Because the issues in child protection and foster care take time to evolve and resolve, CLC staff and volunteer attorneys remain on a child's case for several years. They meet with the child client in the child's setting in advance of the court hearing and learn more about the child's physical and mental health and education situation by talking with the child, teachers, foster parents, social workers, mental health providers, and others connected to the child.

CLC has also leveraged its small staff of attorneys and social workers by training and providing technical support and consultation to over 170 currently active volunteer attorneys who, in 2003, gave 6900 pro bono hours representing children. The retention of volunteer attorneys is also noteworthy as many attorneys have volunteered for CLC since 1997.

CLC's pro bono lawyers, who come from all areas of practice including corporate and securities law, business litigation, intellectual property, to name a few, become advocates themselves for the systemic and structural improvements in the foster care and juvenile court system. Thanks to CLC's training program, consultation with volunteer lawyers, and tracking of CLC cases as they wind their way through the juvenile protection process, volunteer lawyers are more knowledgeable about child protection matters and can be agents for change.¹⁴⁶

They represent children through CLC's projects: the Foster Child Advocacy Project in Ramsey County, and the State Wards Forgotten Children Project in Hennepin County.¹⁴⁷ CLC has also been fortunate to have three consecutive Equal Justice Works

146. *Children's Law Center receives Mission Advocacy Award*, ASIAN AMERICAN PRESS, (Oct. 3, 2003) (on file with author). In 2003, Children's Law Center of Minnesota was the recipient of the Mission Advocacy Award given by the Minnesota Council of Nonprofits for implementing an effective advocacy strategy, demonstrating success in its advocacy efforts, and having a significant impact on its constituency. *Id.*

147. Gail Chang Bohr, *State Wards: The Forgotten Children*, THE HENNEPIN LAW. 4 (Sept. 1999).

fellows since 1999¹⁴⁸ who helped launch the State Wards Project, the Transitions to Independent Living Project, and the Children's Mental Health Project.

CLC's direct representation of youth helped lay the groundwork for systemic change¹⁴⁹ to assist youth "aging out" of foster care establishing a well-formulated independent living plan. Indeed, CLC helped draft legislation for independent living plans for youth in the system. In 2001, the Minnesota Legislature passed legislation requiring the development of an independent living plan for youth, age sixteen and over, leaving foster care.¹⁵⁰ Below are examples of how this legislation affects children in varying situations.

- *Example 1*

Deidre, eighteen, a developmentally delayed young person who also had epilepsy, had been in foster care for most of her life because of her parents' abuse and neglect. CLC had represented Deidre since she was fourteen years old. Without giving notice to Deidre or to her lawyer at CLC, the county asked the court to dismiss Deidre's case even though she still wanted and needed services to help her to live independently. The court dismissed the case. CLC's staff attorney petitioned the court to reopen the case, challenged the dismissal order, and enlisted the help of a volunteer attorney to write the supporting legal memorandum regarding the lack of notice. The CLC was successful in reopening the case. A few months later, when Deidre turned nineteen, the worker again asked for dismissal. This time, although Deidre agreed with dismissal of court jurisdiction, she was afraid that she would not receive any help to make it on her own. In particular, she needed further case management services to help her with job training and coordinating her medical and financial needs. Even though she was delayed developmentally, she did not qualify for adult protection services. The county worker asked the CLC attorney for help; he believed that Deidre would benefit from case management services but he was under pressure to close the case. Based on legal

148. The three Equal Justice Works fellows are: Marian Saksena, Julie Nilsson, and Jaynie Leung.

149. Gail Chang Bohr, *Changing Lives at Children's Law Center, WITH EQUAL RIGHT, THE OFFICIAL JOURNAL OF MINNESOTA WOMEN LAWYERS* 16 (Winter 2003).

150. MINN. STAT. § 260C.212, subd. 1(c) (8) (2005).

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research, CLC requested the court to order the county to continue to provide case management services for Deidre until she turned twenty-one. The court agreed and ordered the county to provide the services.

- *Example 2*

CLC also advocates for appropriate education placement. Sam, a sixteen-year old African American, had been in foster care off and on since 1998—his mother was deceased and he and his father had a confrontational relationship. Diagnosed with attention deficit hyperactive disorder (ADHD), Sam could be verbally aggressive and challenging. Sam called CLC to represent him. He was placed in long-term foster care, was attending regular high school, but later was transferred to a school for students with emotional behavior disorder (EBD). CLC had several meetings at the school to determine his educational needs because the school was not meeting either his academic or emotional needs. A few months later, Sam's foster parent gave notice that he would have to find another foster home. Rather than finding another home, the worker obtained an order, without a hearing, for placement at a facility for delinquent children even though Sam had not done anything wrong. Sam went on the run rather than be placed in that facility. The police eventually picked Sam up when he tried to register for school in the suburbs. CLC filed a motion for a new disposition order arguing that Sam should be placed in a foster home not in the delinquent facility that amounted to being punished for his disability—a clear violation of the Individuals with Disability Education Act. The judge granted the motion and Sam was placed with a relative. Two years later, CLC's advocacy continued as Sam was being discharged from foster care without an independent living plan or services to help him make the transition from foster care.

- *Example 3*

Attorneys also advocate for appropriate placement and treatment. Ricardo, fourteen, is a state ward. Parental rights were terminated two years previously because of domestic violence, chemical dependency, and medical neglect. For five months, he lived with a pre-adoptive family who then changed their minds

about adopting him. When Ricardo's volunteer attorney first met him, Ricardo was adamant that he did not want to be adopted. The county social worker believed that Ricardo was sabotaging adoption recruitment efforts. After a number of months, Ricardo confided in his attorney that the real reasons that he did not want to be adopted were: (1) it would be disloyal to his biological parents; (2) he did not want to change his last name; (3) he did not think anyone would ever *want* to adopt him, (4) even if someone did want to adopt him, he did not want to be adopted by a family that he did not like. His attorney counseled him about his legal rights, including that at age fourteen, he had to give consent to being adopted and that he did not necessarily have to change his surname. His attorney also encouraged Ricardo to see a therapist to deal with his fear that adoption signified disloyalty to his birth parents and his perception that he was "unadoptable." The attorney obtained a court order to ensure that Ricardo received therapy. Ricardo found the counseling to be helpful, and later met several times with a newly identified pre-adoptive family.

- *Example 4*

CLC's attorneys advocate for siblings being placed together and at minimum, that sibling contact be maintained.¹⁵¹ Sisters, Tonya (thirteen) and Tyra (nine) are state wards who have resided together in various foster homes for seven years. In Tonya's seventeen placements and Tyra's six placements they always wanted to live together again. With the siblings having conflicts and the greater possibility that Tyra would be adopted, the county requested sibling separation. Tonya and Tyra both wanted to continue living together and told their CLC attorney so. In addition, the sibling conflicts related to Tonya's behaviors had gone untreated. For example, evaluations ordered when Tonya was six years old were finally undertaken and completed when she was twelve. In one year of treatment, Tonya's behavior improved.

151. Minnesota Statutes section 260C.193, subdivision 3(e) states that "[w]henever possible, siblings should be placed together unless it is determined not to be in the best interests of a sibling. If siblings are not placed together . . . the responsible social services agency shall report to the court the efforts made to place the siblings together and why the efforts were not successful." Furthermore, the court must review the agency's plan for visitation among the siblings if they are not placed together. *Id.*; see also MINN. STAT. § 260C. 212, subd. 1(c)(5).

CLC lawyers successfully argued to the Department of Human Services that separation was not in the sisters' best interest. Since the girls found out that they will not be separated, they have worked hard on lessening the conflict with one another.

Clearly, CLC's advocacy and counseling role with their child clients have an effect on their sense of well-being. As one CLC volunteer lawyer noted, it

is vital to continue to give these children a meaningful opportunity to understand and to influence their own destiny. . . . As an attorney for children such as these, I can advise them about the choices and decisions that will affect them, and I can provide them with a voice to express their fears, their needs and their wishes.¹⁵²

Giving children a voice in proceedings also gives them a sense of control in situations where they feel helpless. Even though the child does not always get what he or she asks for, just the fact that someone is listening and paying attention boosts their self-esteem. One teenage client summed it up after his lawyer had made an impassioned plea, unsuccessfully, for a different placement. He said that this was the first time that anyone had listened to him and actually advocated for what he wanted. He noted that even though the judge had not given him what he had asked for he would nevertheless follow the judge's order because he knew his lawyer had done her best in advocating to the judge for him.

Listening to children is, therefore, the hallmark of representing children because it validates their views and feelings—even when they do not always get what they ask for. Another client praised her lawyer because her lawyer listened to her. Listening without interrupting was a sign of the respect that her lawyer had for her. This listening skill was described by a volunteer lawyer:

I've learned . . . [a] child needs someone to listen to his or her desires and hopes and then to say not, "Well, I don't think that is best for you," but "Okay, let's see what we can do." When you listen to a child wearing your lawyer's hat rather than your parent's hat, it is amazing what you hear. It is also amazing to see what a difference it makes to the child (and it takes time) when they come to realize you are not just one more person telling them what should happen to them or what they must do, but are truly there

152. Letter from Larry D. Espel, Green Espel P.L.L.P., to Children's Law Center of Minnesota (Feb. 21, 2001) (on file with author).

to make sure their voice is heard. If you can establish that trust, you then have a realistic chance of making the system work to the child's advantage, and to the advantage of all.¹⁵³

VIII. CONCLUSION

This article has outlined key statutes and regulations that address the health and well-being of children in the foster care system and described Children's Law Center of Minnesota's advocacy for children. The Adoption Safe Families Act, Child and Family Service Reviews, Early Periodic Screening Diagnosis and Treatment program of Medical Assistance, and the Chafee Foster Care Independence Act all have specific outcome goals for the health and well-being of children in the foster care system.

Federal law and regulations make clear that health and well-being, including education and transition to independent living, are paramount considerations for children in foster care. The education, health and well-being of children in foster care should be the concern of the entire community.

In conclusion, we are reminded that children who are in out-of-home placement are usually there because of abuse or neglect in their families and because we as a society believe that children have a right to a safe, loving home. Therefore, a basic tenet of any child welfare system should be that the system makes children better off with system intervention, or at the very least, not worse. Maintaining the health and well-being of children in foster care is one way the system can leave children better off than they would have been without state intervention. Children's Law Center of Minnesota stands ready to advocate for children's health, education, and well-being. We can do no less.

153. Letter from Chris Hansen, Oppenheimer Wolff & Donnelly L.L.P., to Children's Law Center of Minnesota (Feb. 22, 2001) (on file with author).